Vermont State Hospital Futures Advisory Group
DRAFT MINUTES
1 p.m. to 3 p.m. – February 24, 2006
Health Department
108 Cherry Street, Burlington, VT

The meeting was called to order at approximately 1:15 p.m. by Deputy Commissioner Paul Blake. The names of most of the approximately 30 people present appear at the end of these minutes, although not all members of the public signed in. Public comment was taken towards the end of the meeting.

Following a discussion of the direction that the Futures project has been taking, Anne Donahue offered a motion to reverse the committee's vote of November 16 *(November 16 vote is explained in the note at the end of these minutes).* Donahue said she would vote against her own motion and that she offered it to bring clarity to the situation at hand. It was seconded by Michael Hartman.

David Fassler offered an amendment that the committee endorse the criteria set out in the motion approved on November 16 as a preferred direction, but encourage the Secretary of Human Services to explore all other options *(November 16 criteria are set out in the note at the end of these minutes).* This was identified by Donahue as an unfriendly amendment and was treated as a substitute motion. It was approved on a vote of 8 to 6.

Acknowledging the success of the Fassler motion, Donahue then made a motion that the committee "walk away from" (*i.e.*, reject) the November 16 vote. Again, she said she would vote against the motion. It was seconded by John Malloy. It was defeated on a vote of 1 to 17, meaning that the November 16 vote was not reversed.

The committee used much of the rest of the time to offer questions they would like answered and issues they would like to see addressed. The included:

1. Futures Group members' responsibility to support what the group agrees to. How can Designated Agencies make proposals based on what the Futures Group wants if the committee's position is subject to change? How can we adopt a process such that when a decision is made, agencies can act on it?

2. Will the residential recovery programs actually reduce the VSH census?
3. The state needs a psychiatric intensive care unit, and it will remain at VSH if we don't succeed in building it elsewhere.
4. How many inpatient beds would we have in our system if the proposed new inpatient plan is implemented?
5. In terms of economic viability, what is the most appropriate size for a residential recovery program?
6. How will stigma and discrimination be addressed?
7. What will we provide in an inpatient program or a sub acute program, and how will that help move people toward recovery?
8. Whose ultimate responsibility is it to take care of the sickest people? Are we moving toward privatization?
9. What will the public process consist of in reviewing Designated Agency projects for the commissioner's approval in lieu of a Certificate of Need?
10. We need an updated timeline.
11. We need more information about the legal status of residents in a community recovery residence.
12. Where does voluntary inpatient care fit in the plan?
13. How will we deal with patients who refuse medication?
14. Can the secure residential program be implemented?
15. Who should license the inpatient units?
16. In the context of HIPAA, what are the privacy issuess of the care management system, who will own the software and who will keep the data?

Handouts offered during the meeting included documents with the titles or opening words as follows (all are posted on the Mental Health Update web page, at www.healthyvermonters.info/mh/mhindex.shtml):

1. "Consensus Elements for a Reconfigured Futures Plan," handed out by Tanzman.
2. "1. Program Concept in Place," handed out by Donahue.
3. "Existing" (chart of programs, proposals), handed out by Fassler.
4. "Taking Stock & Moving Forward on Futures," handed out by Lewack.
5. "Statement of Principles Regarding Psychiatric Care," handed out by Fassler.

The meeting was adjourned at approximately 3 p.m.

MEMBERS PRESENT

Linda Corey, by phone
Bea Grause, by phone
Stan Baker
Conor Casey
David Fassler
John Malloy
JoEllen Swaine
Larry Thompson
Jackie Lehman
Diane Bogdan (alternate for Janice Ryan)
Anne Jerman
Ed Paquin
Larry Lewack
Anne Donahue
Sally Parrish
Michael Hartman (alternate for Paul Dupre)
Julie Tessler (alternate for Jeff Rothenberg)

GUESTS
James Patterson
Kevin Finnigan
Michael Hunter
Linda Prez
Maria Besescu
Christine Armstrong
Martha Lang
Scott Thompson
Steve Zind
Eldon Carvey
Dan Barbin

AHS/VDH
Cindy LaWare, AHS
Steve Gold, AHS
Paul Blake, VDH
Beth Tanzman, VDH
John Howland Jr., VDH

NOTE: Motions considered at this February 24, 2006 meeting made reference to the committee's approval of a motion at its meeting of November 16, 2005. At the November 16 meeting, after a series of preliminary votes on amendments, the committee voted to approve a recommendation from its inpatient workgroup that was fairly extensive. The measure approved on November 16, and made reference to in motions considered on February 24, included the following provisions:

"The Futures Advisory Committee should accept the criteria as developed by the inpatient work group. [see below]

"The partner must be prepared to commit to support of the state public policy goal to work towards a system that does not require coercion or the use of involuntary medication."

"Planning for the Futures project, for both inpatient and community services needs to occur in the context of considering the overall financial health of the Designated Hospital and Agency service providers."

"The VSH Futures Advisory Committee notes that its 'support in concept' for the overall Futures plan, and its formal votes regarding advancing specific components, all remain contingent upon the scope of the plan as presented to the legislature last February. We do not believe that, in significant part based on prior direct experience, a replacement inpatient unit alone, with or without the addition of sub-acute beds, can succeed in meeting the needs of the population that VSH serves. These components include the addition of emergency observation, diversion and step-down beds, additional housing, additional community services, additional peer support services, and non-traditional alternatives. It also assumes continuation of adequate resources to sustain all existing community services, including designated inpatient programs, and caseload growth. The Committee notes that the expectation is that it will see appropriate activities and funding for these components in the FY 07 budget in accordance, at a minimum, with the programs identified as and budgeted as coming on line in FY 07 in the timeline that targets a new inpatient facility opening in June, 2010; and that any expedited timeline would also expedite the associated program components in the budget."

The criteria referred to in the November 16 motion, and again in the Fassler motion on February 24, are as follows:

Primary Site & Partner Selection Criteria

1. *The primary VSH replacement service should not be an IMD*
2. *It should be attached to or near (in sight of) a tertiary / teaching hospital*
3. *Only designated hospital inpatient providers shall be considered for the primary VSH-replacement program until such time as it is demonstrated that an agreement cannot be negotiated with one of these partners.*
4. *There must be adequate space to develop or renovate a facility that will accommodate census needs.*
5. *The partner must agree to participate in the care management system. This assures a single standard of care, common clinical protocols, zero reject of eligible admissions etc.*
6. *Costs - both ongoing operations and capital construction - should be considered.*
7. *Outdoor activity space should be readily accessible to the units.*
8. *The ability to attract and retain sufficient specialty staff experienced in psychiatric care should be demonstrated.*
9. *The proposed partner's motivation, track record, and experience in partnering with the state and system of care should be considered.*
10. *Openness and past experience in including consumers/stakeholders in program design and quality monitoring should be demonstrated.*
11. *Willingness to participate in a public reporting of common quality standards is required.*
12. *Ability to deal with expedited planning time frame for full implementation to out-pace five year timeline.*
13. *Ability to collaborate with neighbors.*
14. *Ability to work closely with state and designated agency partners*
15. *The partner must be prepared to commit to support of the state public policy goal to work towards a system that does not require coercion or the use of involuntary medication.*

Smaller Inpatient Capacity(ies)
Site and Partner Selection Criteria

1. *Preference should be given to Designated Hospital inpatient providers until such time as it is demonstrated that an agreement cannot be negotiated with one of these partners.*
2. *A location consideration is to assure adequate distribution of services throughout the state.*
3. *Ability to provide adequate on-site medical care and demonstrated access to hospital medical services.*

The rest of the criteria are the same as for the primary site

4. *Adequate space to develop or renovate a facility that will accommodate census needs.*
5. *The partner must agree to participate in the care management system. This assures a single standard of care, common clinical protocols, zero reject of eligible admissions etc.*
6. *Costs - both ongoing operations and capital construction - should be considered.*
7. *Outdoor activity space should be readily accessible to the units.*
8. *The ability to attract and retain sufficient specialty staff experienced in psychiatric care should be demonstrated.*
9. *The proposed partner's motivation, track record, and experience in partnering with the state and system of care should be considered.*
10. *Openness and past experience in including consumers/stakeholders in program design and quality monitoring should be demonstrated.*
11. *Willingness to participate in a public reporting of common quality standards is required.*
12. *Ability to deal with expedited planning time frame for full implementation to out-pace five year timeline.*
13. *Ability to collaborate with neighbors.*
14. *Ability to work closely with state and designated agency partners*
15. *The partner must be prepared to commit to support of the state public policy goal to work towards a system that does not require coercion or the use of involuntary medication.*

(The Nov. 16 minutes are posted on the Mental Health Update web page: www.healthyvermonters.info/mh/mhindex.shtml)